THE
Great-West Life
ASSURANCE COMPANY

My Group Benefits Plan

BCAA CAA

Flex Plan

We are pleased to offer you our services. As we adhere to principles of inclusion, all genders are incorporated in the language used in our communications with you.

BENEFIT DETAILS

Great-West Life is a leading Canadian life and health insurer. Great-West Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Great-West Life Online

Visit our website at www.greatwestlife.com for:

- information and details on Great-West Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- online claims submission

GroupNet for Plan Members

As a Great-West Life plan member, you can register for GroupNet™ for Plan Members at www.greatwestlife.com/register. Follow the instructions to register. Make sure to have your plan and ID numbers available when registering.

GroupNet™ makes it easier to access benefits information from any device, including:

- your benefit details and claims history
- your personal benefit cards
- online claim submission for most of your claims
- extensive health and wellness content

In addition, by using GroupNet Text, you can get immediate information that is specific to your benefits. GroupNet Text allows you to use your mobile device to access detailed plan information, including:

- plan and member identification numbers
- coverage details (details available depend on your plan design)
- reimbursement amounts
- benefit maximums, balances and more

To use GroupNet Text, text keywords to 204-289-1667. You will receive an instant text back providing information on your coverage. For a complete list of keywords, text Help. For a brief description of the type of information that a keyword provides, text Help along with the specific keyword.

Compatibility of GroupNet Text may vary by mobile device or operating system.

Great-West Life's Toll-Free Number

To contact a customer service representative at Great-West Life:

- for assistance with your medical and dental coverage, please call 1-800-957-9777.
- for assistance with your Health Care Spending Account, please call 1-877-883-7072.

The information provided in the booklet is intended to summarize the contract provisions of Group Policy Nos. 136868, 172563 and 136869 and Plan Document Nos. 51555 and 59394 issued by Great-West Life and Policy No. 100002999 and 011904850 issued to your employer by Industrial Alliance Insurance and Financial Services Inc.. If there are variations between the information in the booklet and the provisions of the policies or plan document, the policies or plan document will prevail to the extent permitted by law.

This booklet contains important information and should be kept in a safe place known to you and your family.

The Plan is administered by

THE Great-West Life ASSURANCE COMPANY

and

Industrial Alliance Insurance and Financial Services Inc.

This booklet was prepared on: December 2, 2019

Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Great-West Life as evidence of insurability, subject to certain limitations.

Legal Actions

Insured benefits

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (for actions or proceedings governed by the laws of Alberta and British Columbia), *The Insurance Act* (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Non-insured benefits

No legal action to recover non-insured benefits under this plan can be introduced for 60 days after notice of claim is submitted, or more than two years after a benefit has been denied.

Appeals

Insured benefits

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Non-insured benefits

You have the right to appeal a denial of all or part of the coverage or benefits described in this plan as long as you do so within two years after the denial. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

Insured benefits

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Great-West Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Great-West Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Great-West Life’s right to use other legal means to recover the overpayment.

Non-insured benefits

If benefits are overpaid you are responsible for repayment within six months, or within a longer period if agreed to by your employer. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit your employer’s right to use other legal means to recover the overpayment.

Protecting Your Personal Information

At Great-West Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- preparing regulatory reports, such as tax slips

Your employer has an agreement with Great-West Life in which your employer has financial responsibility for some or all of the benefits in the plan and we process claims on your employer's behalf. We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As a plan member, you are responsible for the claims submitted. We may exchange personal information with you and a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Great-West Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

Notice of Liability for Benefits

Your employer has entered into an agreement with The Great-West Life Assurance Company whereby the Healthcare and Dentalcare benefits outlined in this booklet are uninsured and your employer has liability for them.

This means that the Healthcare and Dentalcare benefits are:

- an unsecured financial obligation and are payable from your employer's net income, retained earnings or other financial resources; and
- not underwritten by a licensed insurer or regulated insurer.

All claims will, however, be processed by Great-West Life.

If British Columbia law applies, the giving of this notice exempts your employer from the requirements under the Financial Institutions Act (British Columbia).

If Quebec law applies, any communication that you receive from Great-West Life with respect to any uninsured benefit will indicate that it is not under the supervision and control of the Autorité des marchés financiers.

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Benefit Summary

This summary must be read together with the benefits described in this booklet.

Basic Life Insurance	OPTION 1	OPTION 2	OPTION 3
Amount of Coverage	50% of annual earnings to a maximum of $500,000 reducing by 50% at age 65	100% of annual earnings to a maximum of $500,000 reducing by 50% at age 65	200% of annual earnings to a maximum of $500,000 reducing by 50% at age 65

Optional Life Insurance	
Employee	Available in $10,000 units to a maximum of $500,000, subject to approval of evidence of insurability You must elect Option 3 Basic Life Insurance to be eligible for Employee Optional Life Insurance
Spouse	Available in $10,000 units to a maximum of $250,000, subject to approval of evidence of insurability If you are covered under this plan as both an employee and a spouse, you are limited to the $500,000 maximum.
Child	Available in $5,000 units to a maximum of $25,000 per child

Optional Critical Illness Insurance	**OPTION 1**	**OPTION 2**	**OPTION 3**
	Available in $10,000 units to a maximum of $250,000, for you or your spouse, subject to approval of evidence of insurability If you are covered under this plan as both an employee and a spouse, you are limited to the $250,000 maximum Included		

Long Term Disability Income Benefits	**OPTION 1**	**OPTION 2**	**OPTION 3**
Waiting Period	119 days		
Cost-of-Living Allowance (COLA)	Not Included	Not Included	Included - CPI to a maximum of 3%
Taxability	Taxable		
Amount	50% of your monthly earnings to a maximum benefit of $9,000	66 2/3% of your monthly earnings to a maximum benefit of $9,000	66 2/3% of your monthly earnings to a maximum benefit of $9,000

Healthcare			
	OPTION 1		
	Eligible for Out-of-Country Emergency Care and Global Medical Assistance Coverage only		
	OPTION 2	**OPTION 3**	**OPTION 4**
	Covered expenses will not exceed customary charges		
Deductible			
- Individual - Family	$25 each calendar year $25 each calendar year	$25 each calendar year $25 each calendar year	Nil Nil
	The individual and family deductibles do not apply to Global Medical Assistance		
Reimbursement Levels			
Global Medical Assistance and Out-of-Country Emergency Care Expenses	100%		
Visioncare Expenses	20%	80%	100%
All Other Expenses	20% of the first $4,000 in benefits has been paid in a calendar year and 100% for the remainder of the calendar year	80% of the first $4,000 in benefits has been paid in a calendar year and 100% for the remainder of the calendar year	100%

Basic Expense Maximums	**OPTION 2**	**OPTION 3**	**OPTION 4**
In-Canada Hospital	Private room to a maximum of $130 per day		
Home Nursing Care	$15,000 for a maximum of 12 months per condition		
In-Canada Prescription Drugs	Included		
Smoking Cessation Products	$500 lifetime		
Dispensing Fee Limit	The covered expense for the dispensing fee portion of a prescription drug charge is limited to $10.		
Hearing Aids	$700 every 5 years		
Custom-fitted Orthopedic Shoes - Dependent Children - All Others	$200 each calendar year $400 each calendar year		
Custom-made Foot Orthotics	$150 each calendar year		
Myoelectric Arms	$10,000 per prosthesis		
External Breast Prosthesis	1 every 12 months		
Surgical Brassieres	2 every 12 months		
Mechanical or Hydraulic Patient Lifters	$2,000 per lifter once every 5 years		
Outdoor Wheelchair Ramps	$2,000 lifetime		
Blood-glucose Monitoring Machines	1 every 4 years		
Continuous Glucose Monitoring Machines Including Sensors and Transmitters	$4,000 each calendar year		
External Insulin Infusion Pumps	1 every 4 years to a maximum of $6,500		
Transcutaneous Nerve Stimulators	$700 lifetime		
Extremity Pumps for Lymphedema	$1,500 lifetime		
Custom-made Compression Hose	$250 each calendar year		
Wigs for Cancer Patients	$500 lifetime		
Incontinence Supplies	$500 each calendar year	$250 each calendar year	$500 each calendar year

Paramedical Expense Maximums	**OPTION 2**	**OPTION 3**	**OPTION 4**
Acupuncturists	Up to $90 each visit $500 each calendar year	Up to $90 each visit $500 each calendar year	$1,000 each calendar year combined for all practitioners
Chiropractors	Up to $90 each visit $500 each calendar year	Up to $90 each visit $500 each calendar year	
Dieticians	Up to $90 each visit $500 each calendar year	Up to $90 each visit $500 each calendar year	
Massage Therapists	Up to $90 each visit $500 each calendar year	Up to $90 each visit $500 each calendar year	
Naturopaths	Up to $90 each visit $500 each calendar year	Up to $90 each visit $500 each calendar year	
Physiotherapists	Up to $90 each visit $500 each calendar year	Up to $90 each visit $500 each calendar year	
Podiatrists/ Chiropodists	Up to $90 each visit $500 each calendar year	Up to $90 each visit $500 each calendar year	
Speech Therapists	Up to $90 each visit $500 each calendar year	Up to $90 each visit $500 each calendar year	
Psychologists/ Social Workers/ Registered Clinical Counsellors/ Canadian Certified Counsellors	$2,000 each calendar year	$2,000 each calendar year	$2,000 each calendar year
	Paramedical services are reimbursed based on Reasonable & Customary charges		

Visioncare Expense Maximums	**OPTION 2**	**OPTION 3**	**OPTION 4**
Eye Examinations	1 every 24 months to a maximum of $100		
Glasses and Contact Lenses and Laser Eye Surgery	$225 every 24 months	$300 every 24 months	$400 every 24 months
	The 24 month period starts from the day you incur the expense NOT from the date your coverage begins		
Out-of-Country Emergency Care Expenses	$1,000,000 Lifetime		
Lifetime Healthcare Maximum	$1,000,000		
	The lifetime Healthcare Maximum does not apply to Global Medical Assistance		

Dentalcare	**OPTION 2**	**OPTION 3**	**OPTION 4**
	Covered expenses will not exceed customary charges		
Payment Basis	The British Columbia dental fee guide in effect on the date treatment is rendered		
Deductible	Nil		
Reimbursement Levels			
Basic Coverage	20%	100%	100%
Major Coverage	50%	60%	80%
Orthodontic Coverage	50%	50%	60%
Accidental Dental Injury Coverage	20%	100%	100%
Plan Maximums			
Orthodontic Treatment	$2,000 Lifetime	$2,000 Lifetime	$4,000 Lifetime
All Other Treatment	$2,000 each calendar year	$3,000 each calendar year	$3,000 each calendar year
Accidental Dental Injury	Unlimited		

Healthcare Spending Account (HSA)	OPTION 2	OPTION 3	OPTION 4
	BCAA contributes $25 annually		

Wellness Plan	OPTION 2	OPTION 3	OPTION 4
Full-Time Employees	BCAA contributes $250 annually		
Part-Time Employees	BCAA contributes $150 annually		

Basic Accidental Death and Dismemberment Insurance (Underwritten by Industrial Alliance Insurance and Financial Services Inc.)	See Benefit Description

Voluntary Accidental Death and Dismemberment Insurance (Underwritten by Industrial Alliance Insurance and Financial Services Inc.)	See Benefit Description

Information About Your Flex Plan

- Option changes and changes in amounts of optional life insurance take effect each January 1, unless the change results from a change in family status. If it does, the option change will take effect on the date the application for the change is made, as long as it is made within 31 days of the status change. Otherwise, the change will not take effect until the following January 1.

  Note: If you choose option 4 health or dental coverage, you are locked in at that level for 2 years. These restrictions are waived if you are changing options because of a family status change.

  For all increases in optional life insurance (whether as a result of a family status change or otherwise), you must provide proof of insurability and your application for the increase must be approved by Great-West Life.

- If you experience a change in family status during a plan year that affects your coverage needs, you may make changes to your benefit options that directly relate to your status change without waiting for the next January 1 re-enrolment period. Any of the following is considered a change in family status:

  - acquiring your first dependent (spouse or child)
  - acquiring a spouse if you have child coverage only
  - acquiring your first child (birth, adoption or step-child) if you have spouse coverage only
  - involuntary loss of similar coverage through your spouse's group benefit program (for example, because of a change in your spouse's employment status)
  - death of your spouse or only child
  - your spouse or only child ceasing to qualify for coverage (for example, through divorce or your child's attainment of a limiting age – see Dependent Coverage in this booklet)

  Note: See your administrator for details no later than 31 days after a change in family status occurs. Certain conditions apply.

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan on the first day of the month coinciding with or next after your employment begins.

- You and your dependents will be covered as soon as you become eligible.

  You may waive health and/or dental coverage if you are already covered for these benefits under your spouse's plan. If you lose spousal coverage you must apply for coverage under this plan. If you do not apply within 31 days of loss of such coverage, or you were previously declined for coverage by Great-West Life, you and your dependents may be required to provide evidence of good health acceptable to Great-West Life to be covered for health benefits, and may be declined for or offered limited dental benefits.

- You must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work.

  Increases in your benefits while you are covered by this plan will not become effective unless you are actively at work.

- Full-time employees who work less than 15 hours per week may not join the plan.

- Part-time employees who work less than 15 hours per week may not join the plan.

- Temporary and seasonal employees may not join the plan.

Your coverage terminates when your employment ends, you are no longer eligible, or the plan terminates, whichever is earliest.

- Your dependents' coverage terminates when your coverage terminates or your dependent no longer qualifies, whichever is earlier.

- Your coverage may be extended if it would have terminated because you are not actively at work due to disease or injury, temporary lay-off or leave of absence. See your employer for details.

- When your coverage terminates, you may be entitled to an extension of benefits under the plan. See your employer for details.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

  A common-law spouse is a person who has been living with you in a conjugal relationship for at least 12 months.

- Your unmarried children under age 21, or under age 25 if they are full-time students.

  Children under age 21 are not covered if they are working more than 30 hours a week, unless they are full-time students.

  Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 21, or while they are students under 25, and the disorder has been continuous since that time.

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your employer's previous policy prior to the effective date of this policy applies to this policy until you make a change to that designation. You should review your beneficiary designation from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

EMPLOYEE BASIC LIFE INSURANCE

On your death, Great-West Life will pay your life insurance benefits to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

You are only covered for Basic Life Insurance benefits that apply to the option that you choose as shown in the **Benefit Summary.**

- Your life insurance will not continue past the end of the day before the date you reach age 70.

- If you become disabled while insured, Great-West Life may waive the premiums on your life insurance after the waiting period, throughout the benefit period.

  The waiting period is the same as the waiting period under the long term disability income benefit.

  A benefit period is the period of time after the waiting period during which you satisfy the disability definition under the long term disability income benefit. A benefit period will not continue past your 65th birthday.

- Your life insurance will terminate if you are age 65 or over and you are not actively at work. However, if you are not actively at work because of disease or injury, your life insurance may be continued on a premium paying basis for up to 6 months following the date you ceased to be actively at work.

- If any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your employer for details.

OPTIONAL LIFE INSURANCE

Optional life insurance allows you to choose additional coverage for yourself and your dependents. Check the **Benefit Summary** for the amount of optional life insurance available.

When you apply for optional life insurance for yourself or your spouse, you must provide proof of insurability, and the application must be approved by Great-West Life. Great-West Life may void the optional insurance if any statement or answer in your application misrepresents or fails to disclose any fact material to the insurance.

On your death, Great-West Life will pay your life insurance to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements. If one of your dependents dies you will be paid the amount for which that person was insured.

- If you are approved for waiver of premium on your basic life insurance, any optional life insurance for yourself or your dependents will also continue without premium payment as long as your basic life insurance continues but not beyond the date your optional insurance would otherwise terminate.

- If your or your spouse's optional life insurance terminates, you or your spouse may be eligible for an individual conversion policy without providing proof of insurability. You must apply and pay the first premium no later than 31 days after the group insurance terminates. In the case of insurance for your spouse, you or your spouse may apply. See your employer for details.

- Your and your children’s optional life insurance will not continue past the end of the day before the date you reach age 65. Your spouse's coverage will not continue past the end of the day before the date you or your spouse reaches age 65, whichever comes first.

Limitation

No benefit is paid for suicide within the first two years of initial or increased optional life coverage. In such a situation, Great-West Life refunds the premiums that have been received. This limitation does not apply to coverage for a dependent child.

OPTIONAL CRITICAL ILLNESS INSURANCE

If you or your spouse is diagnosed with one of the illnesses defined below while insured, Great-West Life will pay you the optional critical illness insurance benefit. Check the **Benefit Summary** for the amount of insurance available. Where a survival period is specified for a condition below, Great-West Life will not pay the benefit until the end of the survival period. In addition to this benefit, provided it is $10,000 or more, Great-West Life will make a $500 donation in your name to a registered charitable organization of your choice.

If you apply for this optional benefit, you may be required to provide proof of insurability satisfactory to Great-West Life. Only one critical illness benefit is payable in a person's lifetime. Once a benefit has been paid, no further critical illness insurance is available for that person.

Your optional critical illness insurance will not continue past the end of the day before the date you reach age 65. Spouse coverage will not continue past the end of the day before the date you or your spouse reaches age 65, whichever is earlier.

Covered Illnesses

Any of the following conditions is considered a critical illness if it meets the defined criteria and has been diagnosed by a specialist as defined by the policy. The specialist must not be the Group Policyholder, the insured, or a relative or business associate of the Group Policyholder or the insured.

Any tests or examinations that must be performed in order to satisfy the condition requirements must be conducted by a medical professional who is not the Group Policyholder, the insured, or a relative or business associate of the Group Policyholder or the insured.

The diagnosis must be supported by objective medical evidence.

Heart Attack

"Heart Attack" means the death of heart muscle due to obstruction of blood flow, that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a heart attack; or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

Limitations

No benefits will be paid under this condition for:

- elevated biochemical cardiac markers after an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

The benefit is payable after a survival period of 30 days following the date of diagnosis.

Stroke

“Stroke” means an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following the date of the condition. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

Limitations

No benefits will be paid under this condition for:

- transient ischaemic attacks; or
- intracerebral vascular events due to trauma.

For greater certainty, lacunar infarcts which do not have the neurological symptoms and deficits set out above, persisting for more than 30 days, do not satisfy the definition of stroke.

The benefit is payable after a survival period of 30 days following the date of diagnosis.

Coronary Artery Bypass Surgery

“Coronary Artery Bypass Surgery" means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist.

Limitations

No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

The benefit is payable after a survival period of 30 days following the date of surgery.

Cancer (Life-Threatening)

"Cancer (Life-Threatening)" means a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

Limitations

No benefits will be paid under this condition for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.

The term Rai staging is to be applied as explained in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Cancer Exclusion Period

No benefits will be paid under this condition if, within the first 90 days following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of cancer (covered or excluded under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Great-West Life within six months of the date of the diagnosis. If this information is not provided within this period, Great-West Life has the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

Kidney Failure

"Kidney Failure" means chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

Blindness

"Blindness" means the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

Major Organ Transplant

"Major Organ Transplant" means irreversible failure of the heart, both lungs, liver, both kidneys, or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

Dementia, Including Alzheimer's Disease

"Dementia, Including Alzheimer's Disease" means dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech);
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The person must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- evidence of progressive deterioration in cognitive and daily functioning either by serial cognitive tests or by history over at least a six-month period.

Limitations

No benefits will be paid under this condition for affective or schizophrenic disorders, or delirium.

For purposes of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

"Parkinson's Disease" means primary Parkinson's Disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of:

- muscular rigidity; or
- rest tremor.

The person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

"Specified Atypical Parkinsonian Disorders" mean progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

Limitation

No benefits will be paid under this condition for any other type of parkinsonism.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders exclusion period

No benefits will be paid under this condition if, within the first year following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or
- a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Great-West Life within six months of the date of the diagnosis. If this information is not provided within this period, Great-West Life has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

Paralysis

"Paralysis" means total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

Multiple Sclerosis

"Multiple Sclerosis" means at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- well-defined neurological abnormalities lasting more than six months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

Deafness

"Deafness" means the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3000 hertz.

Loss of Speech

"Loss of Speech" means the total and irreversible loss of the ability to speak as a result of physical injury or disease for a period of at least 180 days.

Limitation

No benefits will be paid under this condition for all psychiatric related causes.

Coma

"Coma" means a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be four or less.

Limitation

No benefits will be paid under this condition for a medically induced coma.

Severe Burns

"Severe Burns" means third degree burns over at least 20% of the body surface.

Aortic Surgery

"Aortic Surgery" means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist.

Limitations

No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

The benefit is payable after a survival period of 30 days following the date of surgery.

Benign Brain Tumour

"Benign Brain Tumour" means a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgery or radiation treatment or cause irreversible objective neurological deficits.

Limitation

No benefits will be paid under this condition for pituitary adenomas less than 10 mm.

Benign brain tumour exclusion period

No benefits will be paid under this condition if, within the first 90 days following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of benign brain tumour (covered or excluded under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Great-West Life within six months of the date of the diagnosis. If this information is not provided within this period, Great-West Life has the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

Heart Valve Replacement or Repair

"Heart Valve Replacement or Repair" means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist.

Limitations

No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures

The benefit is payable after a survival period of 30 days following the date of surgery.

Loss of Independent Existence

"Loss of Independent Existence" means the total inability to perform, by oneself, at least two of the following six activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

Activities of daily living are:

- bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- dressing – the ability to put on and remove necessary clothing, braces, artificial limbs, or other surgical appliances with or without the aid of assistive devices;
- toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

Loss of Limbs

"Loss of Limbs" means the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

Motor Neuron Disease

"Motor Neuron Disease" means one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

Occupational HIV Infection

"Occupational HIV Infection" means infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred following the later of the person’s effective date of insurance or, for an increase, the effective date of the increase.

Payment under this condition requires satisfaction of all the following:

- the accidental injury must be reported to Great-West within 14 days of the accidental injury;
- a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- all HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and
- the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

Limitations

No benefits will be paid under this condition if:

- the person has elected not to take any available licensed vaccine offering protection against HIV; or
- a licensed cure for HIV infection has become available prior to the accidental injury.

For greater certainty, non-accidental injury including, but not limited to, sexual transmission or intravenous (IV) drug use does not satisfy the definition of Occupational HIV Infection.

Bacterial Meningitis

"Bacterial Meningitis" means meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis.

Limitation

No benefits will be paid under this condition for viral meningitis.

Aplastic Anaemia

"Aplastic Anaemia" – means chronic persistent bone marrow failure, confirmed by biopsy, which results in anaemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- marrow stimulating agents;
- immunosuppressive agents; or
- bone marrow transplantation.

General Limitations

No benefits are paid for a critical illness resulting directly or indirectly from or associated with any of the following:

- intentionally self-inflicted injury or attempt at suicide, regardless of the person's state of mind and whether or not they were able to understand the nature and consequences of their actions
- war, insurrection or voluntary participation in a riot
- participation in a criminal offence or provoking an assault
- use of any drug, poisonous substance, intoxicant, or narcotic, unless prescribed for the person by a licensed physician and taken in accordance with directions given by the licensed physician
- operating a motorized vehicle while the blood alcohol level is higher than 80 milligrams of alcohol per 100 millilitres of blood.

No benefits are paid if death or irreversible cessation of all functions of the brain occurs during the benefit payment waiting period.

How to Make a Claim

- To claim benefits, obtain a claim form at the Great-West Life website **www.greatwestlife.com**. Complete it and return it to the address shown on the form.

- Claims should be submitted as soon as possible, but no later than 3 months after the earlier of:

    - the end of the critical illness survival period, where applicable; or
    - the date the plan terminates.

LONG TERM DISABILITY (LTD) INCOME BENEFITS

The plan provides you with regular income to replace income lost because of a lengthy disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled **as defined by the policy** or you reach age 65, whichever comes first.

You are only covered for the option that you choose as shown in the **Benefit Summary**.

Check the **Benefit Summary** for the benefit amount and waiting period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 4 weeks and the disabilities arise from the same disease or injury.

- LTD benefits are payable for the first 24 months following the waiting period if disease or injury prevents you from performing the essential duties of your regular occupation, **and**, except for any employment under an approved rehabilitation plan, you are **not** employed in any occupation that is providing you with income equal to or greater than your amount of LTD insurance under this plan, as shown in the Benefit Summary.

- After 24 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and which provides you with an income of at least 60% of your indexed monthly earnings before you became disabled.

- Loss of any license required for work will not be considered in assessing disability.

- After the waiting period, separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 6 months.

- Because your employer contributes to the cost of LTD coverage, benefits are taxable.

- Your LTD insurance will not continue past the end of the day before the date you reach age 65.

Other Income

Your LTD benefit is reduced by other income you are entitled to receive while you are disabled. Your benefit is first reduced by:

- disability or retirement benefits you are entitled to on your own behalf under the Canada Pension Plan or Quebec Pension Plan
- benefits under any Workers' Compensation Act or similar law
- employer sponsored short term disability or sick leave benefits
- loss of income benefits under an automobile insurance plan, to the extent permitted by law

There is a further reduction of your LTD benefit if the total of the income listed below exceeds 85% of your indexed monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

- your income under this plan
- benefits another member of your family is entitled to on the basis of your disability under the Canada Pension Plan or Quebec Pension Plan that are paid directly to you
- loss of income benefits available through legislation, except for Employment Insurance benefits and automobile insurance benefits, which you or another member of your family is entitled to on the basis of your disability
- the wage loss portion of any criminal injury award
- disability benefits under a plan of insurance available through an association
- employment income, disability benefits, or retirement benefits related to any employment except for income from an approved rehabilitation plan, or employer sponsored short term disability or sick leave benefits (termination pay, severance benefits, and any similar termination of employment benefits, including any salary paid in lieu of notice, are included as employment income under this provision)

Earnings received from an approved rehabilitation plan are not used to further reduce your LTD benefit unless those earnings, together with your income from this plan and the other income listed above, would exceed your indexed monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

Cost-of-living increases in the other income listed above, that take effect after the benefit period starts, except for income from an approved rehabilitation plan, are not included.

Vocational Rehabilitation

Vocational rehabilitation involves a work related activity or training strategy that is designed to help you return to your own job or other gainful employment, and is recommended or approved by Great-West Life. In considering whether to recommend or approve a rehabilitation plan, Great-West Life will assess such factors as the expected duration of disability, and the level of activity required to facilitate the earliest possible return to work.

Medical Coordination

Medical coordination is a program, recommended or approved by Great-West Life, that is designed to facilitate medical stability and provide you with cost effective, quality care. In considering whether to recommend or approve a medical coordination program, Great-West Life will assess such factors as the expected duration of disability, and the level of activity required to facilitate medical stability.

Inflation Protection
For employees who choose Option 3 LTD only

One year after the start of your benefit period and annually after that, the then current amount payable will be adjusted to reflect increases in the Consumer Price Index, to a maximum increase of 3% in any year.

Survivor Benefit

If you die while LTD income benefits are being paid, Great-West Life will pay 6 times your monthly LTD benefit to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

Limitations

No benefits are paid for:

- Disability arising from a disease or injury for which you received medical care before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for 1 year, or you have not had medical care for the disease or injury for a continuous period of 90 days ending on or after the date your insurance took effect.

- Any period after you fail to participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.

  Depending on the severity of the condition, you may be required to be under the care of a specialist.

  If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.

- Any period after you fail to cooperate in applying for other disability benefits, reapplying for such benefits, or appealing decisions regarding such benefits, where considered appropriate by Great-West Life.

- Any period after you fail to participate or cooperate in an approved rehabilitation plan.

- Any period after you fail to participate or cooperate in a recommended medical coordination program.

- Any period after you fail to participate or cooperate in a required medical or vocational assessment.

- The scheduled duration of a leave of absence.

  This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy.

- Any period in which you are outside Canada. This exclusion does not apply during the first 30 days of an absence, or if Great-West Life pre-authorized the absence prior to your departure.

- Any period of incarceration, confinement, or imprisonment by authority of law.

- Disability arising from war, insurrection, or voluntary participation in a riot.

Conversion Privilege

If you change jobs, you may apply for an individual LTD conversion policy without medical evidence. You must apply and pay the first premium no later than 31 days after you start your new job, and you must start your new job no later than 6 months after you leave your present one. Your application must be acceptable according to Great-West Life's underwriting rules in effect for individual disability insurance conversion policies at the time of application. See your employer for details.

How to Make a Claim

- To submit claims online, go to www.greatwestlife.com.

- To submit paper claims, obtain an Employee Claim Submission Guide (form M4307B) and follow the guide's instructions.

  You can get this form from your employer, or online from the Great-West Life corporate website. To access the form online, go to www.greatwestlife.com.

Please ensure that your claim is submitted to Great-West Life as soon as possible, but no later than 3 months after proof of your claim has been requested.

HEALTHCARE

A deductible may be applied before you are reimbursed. All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

The plan covers customary charges for the following services and supplies. All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is of a form, intensity, frequency and duration essential to diagnosis or management of the disease or injury.

You are covered for only the Healthcare benefits that apply to the option that you choose as shown in the **Benefit Summary**.

Covered Expenses

- Ambulance transportation to the nearest centre where adequate treatment is available

- Hospital or nursing home confinement or home nursing care if it represents acute, convalescent, or palliative care.

  Acute care is active intervention required to diagnose or manage a condition that would otherwise deteriorate.

  Convalescent care is active treatment or rehabilitation for a condition that will significantly improve as a result of the care and follows a 3-day confinement for acute care.

  Palliative care is treatment for the relief of pain in the final stages of a terminal condition.

  - Preferred accommodation in a hospital or accommodation in a nursing home is covered when provided in Canada.

    For hospital accommodation, the plan covers the difference between the hospital's private and standard ward rates. For out-of-province hospital accommodation, any difference between the hospital's standard ward rate and the government authorized allowance in the person's home province is also covered.

    The plan also covers the hospital facility fee related to dental surgery and any out-of-province hospital out-patient charges not covered by the government health plan in the person’s home province.

    For accommodation in a nursing home, the plan covers the government authorized co-payment.

    Limitation

    Residences established primarily for senior citizens or which provide personal rather than medical care are not covered.

  - The plan covers home nursing services of a registered nurse, a registered practical nurse if the person is a resident of Ontario or a licensed practical nurse if the person is a resident of any other province, when services are provided in Canada.

    Nursing care is care that requires the skills and training of a professional nurse, and is provided by a professional nurse who is not a member of the patient's family.

    You should apply for a pre-care assessment before home nursing begins.

- Drugs and drug supplies described below when prescribed by a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada. Benefits for drugs and drug supplies provided outside Canada are payable only as provided under the out-of-country emergency care provision.

  - Drugs which require a written prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including contraceptive drugs and products containing a contraceptive drug

  - Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered

  - Disposable needles for use with non-disposable insulin injection devices, lancets, test strips, and sensors for flash glucose monitoring machines

  - Extemporaneous preparations or compounds if one of the ingredients is a covered drug

  - Certain other drugs that do not require a prescription by law may be covered. If you have any questions, contact your plan administrator before incurring the expense.

  Unless medical evidence is provided to the plan administrator that indicates why a drug is not to be substituted, the covered expense may be limited to the cost of the lowest priced interchangeable drug.

  For drugs eligible under a provincial drug plan, coverage is limited to the deductible amount and coinsurance you are required to pay under that plan.

- Rental or, at the plan's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician

- Custom-made foot orthotics and custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician

- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician

- Diabetic supplies prescribed by a physician: Novolin-pens or similar insulin injection devices using a needle, blood-letting devices including platforms but not lancets. Lancets are covered under prescription drugs

- Blood-glucose monitoring machines prescribed by a physician

- Flash glucose monitoring machines prescribed by a physician

- Continuous glucose monitoring machines prescribed by a physician, including sensors and transmitters

- External insulin infusion pumps prescribed by a physician

- Diagnostic laboratory and imaging procedures performed in the person's province of residence are covered when that type of procedure is not listed as an insured procedure under their provincial government plan. For greater certainty, a procedure is not eligible for coverage if a person can choose to pay for it, in whole or in part, instead of having the procedure covered under their provincial government plan

- Out-of-hospital services of a qualified acupuncturist
- Out-of-hospital treatment of muscle and bone disorders, excluding diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital treatment of nutritional disorders by a registered dietician
- Out-of-hospital services of a qualified massage therapist
- Out-of-hospital services of a licensed naturopath
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist
- Out-of-hospital treatment of foot disorders, excluding diagnostic x-rays, by a licensed podiatrist
- Out-of-hospital services of a qualified chiropodist
- Out-of-hospital treatment by a registered psychologist, qualified social worker, registered Clinical Counsellor or Canadian Certified Counsellor when service is rendered in British Columbia
- Out-of-hospital treatment of speech impairments by a qualified speech therapist

Visioncare

- Eye examinations, including refractions, when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan
- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician
- Laser eye surgery required to correct vision when performed by a licensed ophthalmologist

Global Medical Assistance Program

This program provides medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains Great-West Life's approval of covered services, when required as a result of a medical emergency arising while you or your dependent is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You must be covered by the government health plan in your home province to be eligible for global medical assistance benefits. The following services are covered, subject to Great-West Life's prior approval:

- On-site hospital payment when required for admission, to a maximum of $1,000

- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment

  When services are covered under this provision, they are not covered under other provisions described in this booklet

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket

- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent’s medical condition, to a maximum of $1,500

- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation

- In case of death, preparation and transportation of the deceased home

- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent’s hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary

- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $1,000.

  Limitation

  Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

Benefits payable for moderate quality accommodation include telephone expenses as well as taxicab and car rental charges.

Limitation

Meal expenses are not covered.

Out-Of-Country Emergency Care

The plan covers medical expenses incurred as a result of a medical emergency arising while you or your dependent is outside Canada for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province.

A medical emergency is a sudden, unexpected injury or an acute episode of disease.

- The following services and supplies are covered when related to the initial medical treatment:

  - treatment by a physician
  - diagnostic x-ray and laboratory services
  - hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while you or your dependent is covered. The maximum payable is $130 per day
  - medical supplies provided during a covered hospital confinement
  - paramedical services provided during a covered hospital confinement
  - hospital out-patient services and supplies
  - medical supplies provided out-of-hospital if they would have been covered in Canada
  - drugs
  - out-of-hospital services of a professional nurse
  - ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available

  If your medical condition permits you to return to Canada, benefits will be limited to the amount payable under this plan for continued treatment outside Canada or the amount payable under this plan for comparable treatment in Canada, plus return transportation, whichever is less.

Other Services and Supplies

Services or supplies that represent reasonable treatment but are not otherwise covered under this plan may be covered by the plan on such terms as the plan administrator determines.

Limitations

A claim for a service or supply that was purchased from a provider that is not approved by the plan administrator may be declined.

The covered expense for a service or supply may be limited to that of a lower cost alternative service or supply that represents reasonable treatment.

Except to the extent otherwise required by law, no benefits are paid for:

- Expenses private benefit plans are not permitted to cover by law

- Services or supplies for which a charge is made only because you have coverage

- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan

- Any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government (“government plan”), without regard to whether coverage would have otherwise been available under this plan

  In this limitation, government plan does not include a group plan for government employees

- Services or supplies that do not represent reasonable treatment

- Services or supplies associated with:
    - treatment performed only for cosmetic purposes
    - recreation or sports rather than with other daily living activities
    - the diagnosis or treatment of infertility
    - contraception, other than contraceptive drugs and products containing a contraceptive drug
- Services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply or determined by the plan administrator to be a covered service or supply
- Extra medical supplies that are spares or alternates
- Services or supplies received outside Canada except as listed under Out-of-Country Emergency Care and Global Medical Assistance
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and benefits would have been paid under this plan for the same services or supplies if they had been received in your home province. No benefits will be payable for any person who is absent from Canada for more than 6 months in a calendar year

  This limitation does not apply to Global Medical Assistance
- Expenses arising from war, insurrection, or voluntary participation in a riot
- Chronic care
- Visioncare services and supplies required by an employer as a condition of employment

In addition and except to the extent otherwise required by law, under the prescription drug coverage, no benefits are paid for:

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- Any single purchase of drugs which would not reasonably be used within 100 days
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital

- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason
- Preventative immunization vaccines and toxoids
- Fertility drugs, whether or not prescribed for a medical reason
- Drugs used to treat erectile dysfunction

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, the plan administrator maintains a limited list of services and supplies that require prior authorization.

For services and supplies, including a listing of the prior authorization drugs, go to www.greatwestlife.com.

Prior authorization is intended to help ensure that a service or supply represents a reasonable treatment.

If the use of a lower cost alternative service or supply represents reasonable treatment, you or your dependent may be required to provide medical evidence to the plan administrator why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

The plan administrator may contact you to participate in health case management. Health case management is a program recommended or approved by the plan administrator that may include but is not limited to:

- consultation with you or your dependent and the attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison, with the attending physician, of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- identification to the attending physician of opportunities for education and support; and
- monitoring your or your dependent's adherence to the treatment plan recommended by the person's attending physician.

In determining whether to implement health case management, the plan administrator may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

The payment of benefits for a service or supply may be limited, on such terms as the plan administrator determines, where:

- the plan administrator has implemented health case management and you or your dependent do not participate or cooperate; or
- you or your dependent have not adhered to the treatment plan recommended by his attending physician with respect to the use of the service or supply.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where the plan administrator has recommended or approved health case management, the plan administrator can require that a service or supply be purchased from or administered by a provider designated by the plan administrator, and:

- the covered expense for a service or supply that was not purchased from or administered by a provider designated by the plan administrator may be limited to the cost of the service or supply had it been purchased from or administered by the provider designated by the plan administrator; or
- a claim for a service or supply that was not purchased from or administered by a provider designated by the plan administrator may be declined.

Patient Assistance Program

A patient assistance program may provide financial, educational or other assistance to you or your dependents with respect to certain services or supplies.

If you or your dependents are eligible for a patient assistance program, you or your dependent may be required to apply to and participate in such a program. Where financial assistance is available from a patient assistance program the plan administrator requires participation in, the covered expense for a service or supply may be reduced by the amount of financial assistance you or your dependent is entitled to receive for that service or supply.

How to Make a Claim

- **Out-of-country claims (including those for Global Medical Assistance expenses)** should be submitted to Great-West Life as soon as possible after the expense is incurred. It is very important that you send your claims to the Great-West Life Out-of-Country Claims Department immediately as your Provincial or Territorial Medical Plan has very strict time limitations.

  Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M5432 (Statement of Claim Out-of-Country Expenses form) from your employer. You must also obtain the Government Assignment form, and residents of British Columbia, Quebec and Newfoundland & Labrador must also obtain the Special Government Claim form. The Great-West Life Out-of-Country Claims Department will forward the appropriate government forms to your attention when required.

  You should complete all applicable forms, making sure all required information is included. Attach all original receipts and forward the claim to the Great-West Life Out-of-Country Claims Department. Be sure to keep a copy for your own records. The plan will pay all eligible claims including your Provincial or Territorial Medical Plan portion. Your Provincial or Territorial Medical Plan will then reimburse the plan for the government's share of the expenses.

  Out-of-country claims must be submitted within a certain time period that varies by province or territory. For the claims submission period applicable in your province or territory or for any other questions or for assistance in completing any of the forms, please contact Great-West Life's Out-of-Country Claims Department at
  1-800-957-9777.

- **Claims for expenses incurred in Canada, for paramedical services and visioncare**, may be submitted online. To use this online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  Online claims must be submitted to Great-West Life as soon as possible, but no later than 6 months after you incur the expense.

  You must retain your receipt for 12 months from the date you submit your claim to Great-West Life as a record of the transaction, and you must submit it to Great-West Life on request.

- **For all other Healthcare claims**, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M635D from your employer. Complete this form making sure it shows all required information.

  Attach your receipts to the claim form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 15 months after you incur the expense.

- **For drug claims**, your employer will provide you with a prescription drug identification card. Present your card to the pharmacist with your prescription.

  Before your prescription is filled, an Assure Claims check will be done. Assure Claims is a series of seven checks that are electronically done on your drug claim history for increased safety and compliance monitoring. This has been designed to improve the health and quality of life for you and your dependents. Checks done include drug interaction, therapeutic duplication and duration of therapy, allowing the pharmacist to react prior to the drug being dispensed. Depending on the outcome of the checks, the pharmacist may refuse to dispense the prescribed drug.

  When your coverage ends, return your direct pay drug identification card to your employer.

DENTALCARE

All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

The plan covers customary charges to the extent they do not exceed the dental fee guide level shown in the **Benefit Summary**. Denturist fee guides are applicable when services are provided by a denturist. Dental hygienist fee guides are applicable when services are provided by a dental hygienist practising independently.

All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is recognized by the Canadian Dental Association, it is proven to be effective, and it is of a form, frequency, and duration essential to the management of the person's dental health. To be considered reasonable, treatment must also be performed by a dentist or under a dentist's supervision, performed by a dental hygienist entitled by law to practise independently, or performed by a denturist.

You are covered for only the dentalcare benefits that apply to the option that you choose as shown in the **Benefit Summary**.

Treatment Plan

- Before incurring any large dental expenses, or beginning any orthodontic treatment, ask your dental service provider to complete a treatment plan and submit it to the plan. The benefits payable for the proposed treatment will be calculated, so you will know in advance the approximate portion of the cost you will have to pay.

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
    - one complete oral examination every 36 months
    - limited oral examinations twice each calendar year for dependent children and once each calendar year for any other covered person, except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed
    - limited periodontal examinations twice each calendar year for dependent children and once each calendar year for any other covered person
    - complete series of x-rays every 36 months
    - intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered

- Preventive services including:
    - polishing and topical application of fluoride each twice each calendar year for dependent children and once each calendar year for any other covered person
    - scaling, limited to a maximum combined with periodontal root planing of 16 time units each calendar year

      A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
    - pit and fissure sealants on bicuspids and permanent molars every 60 months
    - space maintainers including appliances for the control of harmful habits
    - finishing restorations
    - interproximal disking
    - recontouring of teeth
- Minor restorative services including:
    - caries, trauma, and pain control
    - amalgam, bonded amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan
    - retentive pins and prefabricated posts for fillings
    - prefabricated crowns for primary teeth
- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months
- Periodontal services including:
    - root planing, limited to a maximum combined with preventive scaling of 16 time units each calendar year
    - occlusal adjustment and equilibration, limited to a combined maximum of 16 time units each calendar year

      A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
- Denture maintenance, including:
    - denture relines for dentures at least 6 months old, once every 36 months
    - denture rebases for dentures at least 2 years old, once every 36 months
    - resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 36 months
- Oral surgery
- Adjunctive services

Major Coverage

- Crowns. Coverage for complicated crowns is limited to the cost of standard crowns
- Onlays

  Replacement crowns and onlays are covered when the existing restoration is at least 5 years old and cannot be made serviceable

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when required to replace one or more teeth extracted while the person is covered. Overdentures and bridgework are covered only when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Replacement appliances are covered only when:

  - the existing appliance is a covered temporary appliance
  - the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable while the person is covered and as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

    If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth

- Denture-related surgical services for remodelling and recontouring oral tissues
- Appliance maintenance following the 3-month post-insertion period including:

  - denture remakes, once every 36 months
  - denture adjustments, once every 12 months
  - denture repairs and additions, tissue conditioning and resetting of denture teeth
  - repairs to covered bridgework
  - removal and recementation of bridgework

Orthodontic Coverage

- Orthodontics are covered for persons age 6 or over when treatment starts

Accidental Dental Injury Coverage

- Treatment of injury to sound natural teeth. Treatment must start within 60 days after the accident unless delayed by a medical condition

  A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced

Limitations

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, any oral hygiene instruction and nutritional counselling
- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants
- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations
- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage
- Hypnosis or acupuncture
- Veneers, recontouring existing crowns, and staining porcelain
- Crowns or onlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings
- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.

  If overdentures are provided, coverage will be limited to standard complete dentures.

  If initial bridgework is provided, coverage will be limited to a standard cast partial denture and restoration of abutment teeth when required for purposes other than bridgework

  If additional bridgework is performed in the same arch within 60 months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework

  Benefits will be limited to standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, partial overdentures and dentures and bridgework related to implants are provided
- Expenses covered under another group plan's extension of benefits provision
- Accidental dental injury expenses for treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services
- Expenses private benefit plans are not permitted to cover by law
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have coverage

- Services or supplies that do not represent reasonable treatment
- Treatment performed for cosmetic purposes only
- Congenital defects or developmental malformations in people 19 years of age or over, except orthodontics
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot

How to Make a Claim

- **Claims for expenses incurred in Canada** may be submitted online. Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your employer and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  Online claims must be submitted to Great-West Life as soon as possible, but no later than 6 months after the dental treatment.

  You must retain your receipt for 12 months from the date you submit your claim to Great-West Life as a record of the transaction, and you must submit it to Great-West Life on request.

- **For all other Dentalcare claims**, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your employer. Have your dental service provider complete the form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 15 months after the dental treatment.

HEALTH CARE SPENDING ACCOUNT BENEFITS (HCSA)

A Health Care Spending Account (HCSA) is like a bank account through which you may be reimbursed for health and dental expenses up to a predetermined annual credit amount. Your employer will establish the credits for your account prior to each plan year. These credits may be used to cover expenses not covered by group health plans or to top-up expenses not fully covered by group health plans, including deductibles and co-payment amounts. Also, since annual credits are in the form of before tax dollars, the HCSA is a tax-effective way of paying for your health-related expenses.

Eligibility

You and your dependents are eligible for HCSA credits through your employer if you are covered for basic health care benefits or basic dental care benefits under your or your spouse's group health plan. In addition to the dependents eligible for coverage under your group health plan, HCSA benefits are extended to any other person for whom you are entitled to claim a medical expense tax credit under the *Income Tax Act* (Canada).

You may apply for HCSA benefits within 31 days of the date you first become eligible or at your plan's annual enrolment date.

Termination

Your HCSA coverage terminates when your health plan coverage terminates, when you elect to discontinue coverage (at any plan enrolment date) or when your employer discontinues the plan.

Your dependents' HCSA coverage terminates when your coverage terminates or when they no longer qualify, whichever is earlier.

Covered Expenses

Coverage is provided for those expenses that qualify for a medical expense tax credit under the Income Tax Act (Canada), as may be amended from time to time.

Please refer to the Canada Revenue Agency website for information on medical expenses that qualify for the medical expense tax credit under the Income Tax Act (Canada). For additional information on covered expenses, contact a customer service representative at Great-West Life toll-free at 1-877-883-7072.

Benefits will be paid for 100% of covered expenses that are incurred while you and your dependents are covered, up to a maximum annual payment equal to the credits in your HCSA. Dental expenses, other than orthodontic expenses, are considered to be incurred when treatment is completed. Orthodontic expenses are considered to be incurred on a periodic basis throughout the course of treatment. All other expenses are considered to be incurred when they are received.

Credits are available for covered expenses incurred in a plan year. Any remaining credits will be carried forward for covered expenses incurred in the following plan year. If they are not used for expenses incurred in that plan year, they are automatically forfeited.

The maximum annual payment available under your account will consist of the amount of the credit directed to it for the plan year plus any unused amount from the previous year.

Limitations

No benefits are paid for:

- Expenses that private benefit plans are not permitted to cover by law
- Services or supplies you are entitled to without charge by law or for which a charge is made only because you have coverage under a private benefit plan
- Any portion of the expense for services or supplies for which benefits are payable under your basic health plan, another group plan or a government plan

How to Make a Claim

The HCSA will reimburse you for the balance of the expense remaining after all other insurance plans have paid out. You must first submit all claims to any government and private insurance plans under which you or any eligible dependents are covered. Once you have received reimbursement for the expense from all other plans, you may submit a claim against the HCSA.

Claims against the HCSA may be submitted on a claim form. Claims for paramedical services, visioncare and dentalcare expenses incurred in Canada may also be submitted online.

- To submit claims using a claim form, please see your plan administrator to obain the HCSA claim form or use the form available from GroupNet.
- To submit claims online, you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online

  You must retain your receipt for 12 months from the date you submit your claim to Great-West Life as a record of the transaction, and you must submit it to Great-West Life on request.

Claims against the HCSA must be submitted to the Great-West Life Benefit Payment Office before the earliest of the following:

- 31 days after the end of the plan year in which the expenses are incurred
- the date the HCSA contract terminates, if it terminates because your employer fails to make a required payment
- 31 days after the date the HCSA contract terminates, if it terminates for any other reason

COORDINATION OF BENEFITS

- Benefits for you or a dependent will be directly reduced by any amount payable under a government plan. If you or a dependent are entitled to benefits for the same expenses under another group plan or as both an employee and dependent under this plan or as a dependent of both parents under this plan, benefits will be co-ordinated so that the total benefits from all plans will not exceed expenses.

- You and your spouse should first submit your own claims through your own group plan. Claims for dependent children should be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). If you are separated or divorced, the plan which will pay benefits for your children will be determined in the following order:

  1. the plan of the parent with custody of the child;
  2. the plan of the spouse of the parent with custody of the child;
  3. the plan of the parent without custody of the child;
  4. the plan of the spouse of the parent without custody of the child

  You may submit a claim to the plan of the other spouse for any amount which is not paid by the first plan.

DIAGNOSTIC AND TREATMENT SUPPORT SERVICES (BEST DOCTORS® SERVICE)

This service is designed to allow access to the expertise of specialists, resources, information and clinical guidance.

You, your dependents, parents and parents in-law (each a "person" for the purpose of this service) can generally access this service. This service is made up of a unique step-by-step process that may help address questions or concerns about a serious physical or mental illness or condition. This may include confirming the diagnosis and suggesting the most effective treatment plan by drawing on a global database of up to 50,000 peer-ranked specialists.

How it works

- Access diagnostic and treatment support services by calling 1-877-419-BEST (2378) toll-free.

- The person accessing the service will be connected with a member advocate who will be dedicated to the person's case and will provide support through the process. The member advocate will take the necessary medical history and answer the person's questions. Any information provided is not shared with either your employer or the administrator of your health plan.

- Based on the information provided, the member advocate determines the optimal level of service required.

- The member advocate may provide information, resources, guidance and advice individually tailored to meet the person's health needs, and can help identify individual community supports and resources available.

- If it is appropriate, the member advocate may arrange for an in-depth review of the person's medical file to assist in confirming the diagnosis and help develop a treatment plan. This review may include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing test results. A written report outlining the conclusions and recommendations of the specialists will be forwarded to the person accessing the service. Generally, this process takes 6 to 8 weeks. Timeframes may vary depending on the complexity of the case and amount of medical records to collect.

- If the person decides to seek treatment by a different physician, the member advocate can help identify a specialist qualified to meet the person's specific medical needs.

  Limitation

  Expenses incurred for travel and treatment are not covered by this service.

- If the person decides to seek treatment outside Canada, the member advocate can arrange referrals and can help book accommodations. The member advocate can also assist in accessing hospital and physician discounts, arrange for the forwarding of medical information and monitor the treatment process.

  Limitation

  Expenses incurred for travel and treatment are not covered by this service.

- The member advocate may identify a Best Doctors specialist suited to answer basic questions about health concerns and treatment options. Answers will be provided in a written report sent by email to the person accessing the service.

Access to this service may be restricted to persons for whom their physician has made a diagnosis of a serious physical or mental illness or condition for which there is objective evidence, or where a serious physical or mental illness or condition is suspected.

These services are not insured services. Great-West Life is not responsible for the provision of the services, their results, or any treatment received or requested in connection with the services.

BRITISH COLUMBIA AUTOMOBILE ASSOCIATION

SUMMARY OF INSURANCE COVERAGE

Policy No. 100002999 issued by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

You are covered for a principal sum amount of $15,000.00, if an injury is sustained as the result of any accident anywhere in the world - 24 hours per day - on or off the job.

ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS INDEMNITY

The “loss” or “loss of use” must occur within 365 days of the date of the accident. These benefits are payable on a lump sum basis and in addition to any other benefits you may receive.

	% of Principal Sum
Life	100%
Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Arm	75%
One Leg	75%
One Hand	75%
One Foot	75%
Entire Sight of One Eye	75%
Speech or Hearing in Both Ears	66⅔%

Thumb and Index Finger of Either Hand 33⅓%

Four Fingers of Either Hand.....33⅓%

Hearing in One Ear 33⅓%

All Toes of One Foot 25%

Quadriplegia (total paralysis of all four limbs) 200%

Paraplegia (total paralysis of the lower limbs).....200%

Hemiplegia (total paralysis of one side of the body) 200%

BEREAVEMENT BENEFIT ($1,000)

If an injury results in loss of life, the Company will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children for up to six (6) sessions of grief counselling, by a professional counsellor.

CONVERSION OPTION

Upon termination of active employment with the Policyholder, an insured may convert his/her insurance to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination. Application for conversion must be made within 31 days. Premiums become payable annually in advance.

COSMETIC DISFIGUREMENT BENEFIT

If an Insured Person suffers cosmetic disfigurement due to a third-degree burn as a result of a non-occupational injury, the Company will pay a percentage of the Principal Sum depending on the area of the body which was burned, subject to a maximum of $25,000.00.

CRITICAL DISEASE BENEFIT

If an Insured Person, prior to age 65, is diagnosed by a specialist with a Covered Disease while this policy is in force and is totally disabled from the Covered Disease for at least nine months following the date of diagnosis, the Company will pay ten percent of the Principal Sum up to a maximum of $50,000.00. This benefit is payable only if investigations leading to the diagnosis of a Covered Disease are initiated more than 90 days following the effective date of insurance with respect to an Insured Person. Payment of the Critical Disease Benefit is limited to only the first covered disease to occur.

"**Covered Disease**" means Acute Poliomyelitis, Acute Rheumatic Fever, Amyotrophic Lateral Sclerosis (ALS), Encephalitis, Huntington's Disease, Meningitis, Necrotizing Fasciitis, Parkinson's Disease, Tuberculosis, Typhoid Fever and Yersinia Pestis.

DAY CARE BENEFIT ($5,000)

If injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed four years) for each dependent child who is under 13 years of age and enrolled in a legally licensed day care centre on the date of, or within 12 months following the accident.

EDUCATION BENEFIT ($5,000)

If injury results in loss of life, the Company will pay 5% of the principal sum to any dependent child who, on the date of the accident, was enrolled as a full-time student in any institution of higher learning beyond the secondary school level (not to exceed four years). If, at the time of loss, there are no dependent children eligible for the Education Benefit, the Company shall pay an additional amount of $2,500.00 to the designated beneficiary.

FAMILY TRANSPORTATION BENEFIT ($15,000)

If injury results in confinement as an inpatient in a hospital, and such injury results in a loss being payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, and the hospital is located at least 150 km from the insured's residence, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.20 per kilometre travelled.

FUNERAL EXPENSE BENEFIT ($5,000)

If injury results in loss of life, an additional amount is payable for funeral expenses actually incurred.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT ($15,000)

If injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

HOSPITAL INDEMNITY EXPENSE ($2,500)

A daily benefit, subject to the above-mentioned monthly maximum, will be payable when the insured is in a hospital if such period of hospitalization is necessary for the treatment of an injury which results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity of the policy and begins while insurance is in force.

A period of hospitalization necessary for an injury other than for a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity will be covered as stated above, provided such hospitalization is of at least a four day period.

IDENTIFICATION BENEFIT ($15,000)

If injury results in loss of life, and requires body identification, the Company will pay the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route, provided the body is located not less than 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.20 per kilometre travelled.

REHABILITATION BENEFIT ($25,000)

If injury requires that the insured undergo special training in order to be qualified to engage in a special occupation in which the insured would not have engaged except for such injury, the Company will pay the reasonable and necessary expense incurred for such training, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

REPATRIATION BENEFIT ($25,000)

If injury results in loss of life, the Company will pay the expense incurred for shipment of the body to the city of residence of the deceased.

SEAT BELT BENEFIT

If injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the principal sum will be increased by 10% to a maximum of $25,000 if, at the time of the accident, the insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

SPOUSAL RETRAINING BENEFIT ($15,000)

If injury results in loss of life, the Company will reimburse the spouse for the actual expenses incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

WAIVER OF PREMIUM

In the event of total disability and waiver of premium has been approved and accepted by the group life carrier, then premium under this plan will be waived until the earlier of: death, recovery, attainment of age 65 or the date the policy is cancelled.

LIMITED AIR TRAVEL COVERAGE

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew; in boarding or alighting from or being struck by; or making a forced landing with or from:

(a) any aircraft having a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or

(b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on, boarding or alighting from or being struck by or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

TERMINATION OF INSURANCE OF AN INSURED

Coverage will terminate immediately on the earliest of: (a) the policy termination date; (b) the premium due date if the Policyholder fails to pay the insured’s premium, except as a result of an inadvertent error; (c) the premium due date coinciding with or immediately following the date an insured attains age 70; (d) the premium due date next following the date an Insured Person ceases to be associated with the Policyholder in a capacity making such person eligible for insurance hereunder.

WHEN DOES THIS INSURANCE NOT APPLY?

- declared or undeclared war or any act thereof;
- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the part titled “Limited Air Travel Coverage”.

BENEFICIARY

Indemnity payable in the event of the loss of life of an insured is payable in accordance with the beneficiary designation in effect under the Policyholder's current Basic Group Life Insurance policy. Unless otherwise indicated and if there is no such designation, the indemnity is payable to the estate of the insured. All other indemnities are payable to the insured, with the exception of indemnities payable under the following parts:

Bereavement Benefit	Education Benefit
Day Care Benefit	Spousal Retraining Benefit

In the situation where the policy replaces an existing policy issued to the Policyholder, the designation recorded under the replaced policy will be deemed to be valid and of full force and effect under this policy until changed in writing by the insured.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

This summary is for information purposes only. For further details, refer to the Master Policy which is on file with the Policyholder. The Master Policy sets forth in detail the terms and conditions of the Plan and all rights and obligations are determined in accordance with the Master Policy issued by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc., not this summary.

BRITISH COLUMBIA AUTOMOBILE ASSOCIATION

SUMMARY OF INSURANCE COVERAGE

Policy No. 011904850 issued by Special Markets Solutions, a division of

Industrial Alliance Insurance and Financial Services Inc.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If you elect to participate, you are covered for injuries sustained as the result of any accident anywhere in the world - 24 hours per day - on or off the job, for the principal sum amount you have selected. You may select any principal sum of insurance from a minimum of $10,000.00 to a maximum of $250,000.00, in units of $10,000.00.

You may also elect to insure your family. Your Spouse may any principal sum of insurance from a minimum of $10,000.00 to a maximum of $250,000.00, in units of $10,000.00. Your Dependent Child(ren) may select any principal sum of insurance from a minimum of $10,000.00 to a maximum of $30,000.00, in units of $10,000.00.

ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS INDEMNITY

The "loss" or "loss of use" must occur within 365 days after the date of the accident. These benefits are payable on a lump sum basis and in addition to any other benefits you may receive.

	% of Principal Sum
Life	100%
Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Arm	75%
One Leg	75%
One Hand	75%
One Foot	75%
Entire Sight of One Eye	75%
Speech or Hearing in Both Ears	66⅔%
Thumb and Index Finger of Either Hand	33⅓%
Four Fingers of Either Hand	33⅓%
Hearing in One Ear	33⅓%
All Toes of One Foot	25%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

BEREAVEMENT BENEFIT ($1,000)

If an injury results in loss of life, the Company will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children for up to six (6) sessions of grief counselling, by a professional counsellor.

CONVERSION OPTION

Upon termination of active employment with the Policyholder, an insured may convert his/her insurance to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination. Application for conversion must be made within 31 days. Premiums become payable annually in advance.

COSMETIC DISFIGUREMENT BENEFIT

If an Insured Person suffers cosmetic disfigurement due to a third-degree burn as a result of a non-occupational injury, the Company will pay a percentage of the Principal Sum depending on the area of the body which was burned, subject to a maximum of $25,000.00.

CRITICAL DISEASE BENEFIT

If an Insured Person, prior to age 65, is diagnosed by a specialist with a Covered Disease while this policy is in force and is totally disabled from the Covered Disease for at least nine months following the date of diagnosis, the Company will pay ten percent of the Principal Sum up to a maximum of $50,000.00. This benefit is payable only if investigations leading to the diagnosis of a Covered Disease are initiated more than 90 days following the effective date of insurance with respect to an Insured Person. Payment of the Critical Disease Benefit is limited to only the first covered disease to occur.

"**Covered Disease**" means Acute Poliomyelitis, Acute Rheumatic Fever, Amyotrophic Lateral Sclerosis (ALS), Encephalitis, Huntington's Disease, Meningitis, Necrotizing Fasciitis, Parkinson's Disease, Tuberculosis, Typhoid Fever and Yersinia Pestis.

DAY CARE BENEFIT ($5,000)

If injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed four years) for each dependent child who is under 13 years of age and enrolled in a legally licensed day care centre on the date of, or within 12 months following the accident.

EDUCATION BENEFIT ($5,000)

If injury results in loss of life, the Company will pay 5% of the principal sum to any dependent child who, on the date of the accident, was enrolled as a full-time student in any institution of higher learning beyond the secondary school level (not to exceed four years). If, at the time of loss, there are no dependent children eligible for the Education Benefit, the Company shall pay an additional amount of $2,500.00 to the designated beneficiary.

FAMILY TRANSPORTATION BENEFIT ($15,000)

If injury results in confinement as an inpatient in a hospital, and such injury results in a loss being payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, and the hospital is located at least 150 km from the insured's residence, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.20 per kilometre travelled.

FUNERAL EXPENSE BENEFIT ($5,000)

If injury results in loss of life, an additional amount is payable for funeral expenses actually incurred.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT ($15,000)

If injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

HOSPITAL INDEMNITY EXPENSE ($2,500)

A daily benefit, subject to the above-mentioned monthly maximum, will be payable when the insured is in a hospital if such period of hospitalization is necessary for the treatment of an injury which results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity of the policy and begins while insurance is in force.

A period of hospitalization necessary for an injury other than for a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity will be covered as stated above, provided such hospitalization is of at least a four day period.

IDENTIFICATION BENEFIT ($15,000)

If injury results in loss of life, and requires body identification, the Company will pay the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route, provided the body is located not less than 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.20 per kilometre travelled.

REHABILITATION BENEFIT ($25,000)

If injury requires that the insured undergo special training in order to be qualified to engage in a special occupation in which the insured would not have engaged except for such injury, the Company will pay the reasonable and necessary expense incurred for such training, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

REPATRIATION BENEFIT ($25,000)

If injury results in loss of life, the Company will pay the expense incurred for shipment of the body to the city of residence of the deceased.

SEAT BELT BENEFIT

If injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the principal sum will be increased by 10% to a maximum of $25,000 if, at the time of the accident, the insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

SPOUSAL RETRAINING BENEFIT ($15,000)

If injury results in loss of life, the Company will reimburse the spouse for the actual expenses incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

WAIVER OF PREMIUM

In the event of total disability and waiver of premium has been approved and accepted by the group life carrier, then premium under this plan will be waived until the earlier of: death, recovery, attainment of age 65 or the date the policy is cancelled.

LIMITED AIR TRAVEL COVERAGE

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew; in boarding or alighting from or being struck by; or making a forced landing with or from:

(a) any aircraft having a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or

(b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on, boarding or alighting from or being struck by or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

TERMINATION OF INSURANCE OF AN INSURED

Coverage will immediately terminate on the earliest of:

A. For the participant: (a) the policy termination date; (b) the premium due date if the Policyholder fails to pay the participant's premium, except as a result of an inadvertent error; (c) the premium due date coinciding with or immediately following the date a participant attains age 70 or age 70 with respect to the insured Spouse; (d) the premium due date next following the date a participant is ineligible for coverage

B. For the insured dependent child: (a) the date such person becomes ineligible for coverage; and (b) the date the participant's insurance is terminated.

WHEN DOES THIS INSURANCE NOT APPLY?

- declared or undeclared war or any act thereof;
- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the part titled "Limited Air Travel Coverage".

BENEFICIARY

Indemnity payable in the event of the loss of life of a participant is payable to the beneficiary or beneficiaries designated in writing by the participant on his enrolment card on file with the Policyholder, or if there is no such beneficiary designation with respect to the participant, such indemnity is payable to the estate of the participant. All other indemnities payable, including those payable for the insured Spouse and/or insured Dependent Children, are payable to the Participant.

In the situation where the policy replaces an existing policy issued to the Policyholder, the beneficiary designation recorded under the replaced policy will be deemed to be valid and of full force and effect until changed in writing by the participant.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

This summary is for information purposes only. For further details, refer to the Master Policy which is on file with the Policyholder. This Master Policy sets forth in detail the terms and conditions of the Plan and all rights and obligations are determined in accordance with the Master Policy issued by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc., not this summary.

GuidanceResources® is an added benefit that gives you and your family confidential support, resources and information for personal and work-life issues and is offered **at no charge.**

What the GuidanceResources® Program (EAP) offers

- **Counselling** provides you and your family with support for an array of life challenges including, marital, relationship and family issues, stress, anxiety, depression, grief, loss, job pressures and substance abuse.
- **Work-life services** connects you with specialists who can provide qualified referrals and customized resources for child and elder care, moving, pet care, post-secondary education planning, home repair, buying a car, planning an event, selling a house and more.
- **Legal support services** connects you with a licensed lawyer who can address your legal concerns such as divorce, custody, adoption, real estate, debt, immigration, bankruptcy, landlord/tenant issues, civil and criminal actions and more.
- **Financial information services** provides consultations with financial professionals to answer questions about budgeting, debt management, tax issues and other money concerns, simply by calling the toll-free number.
- **Wellness services** (such as HealthyGuidance®) provide you and your family with tools and resources to help you make positive lifestyle changes.
- **GuidanceResources® Online** allows you to ask your questions and access timely, expert information on several topics – relationships, work, school, child and elder care, physical and financial wellness, legal issues and more.

Available 24 hours a day, 7 days a week

There are two ways to access your EAP resource:

1. Call**: 844-543-3207**. You'll speak to a counselling professional who will listen to your concerns and can guide you to the appropriate services you require.
2. Visit GuidanceResources® Online at www.guidanceresources.com and enter your web ID: **BCAA**

We encourage you to take some time to explore all the benefits that the EAP can offer you and your family. Please remember that all EAP services are strictly confidential.